INDIVIDUALIZED CONTACT PLAN FOR FAMILY PLANNING

I, (print or type name)_____,
request the following special plan to contact me regarding my family planning visits:

_____

_____

_____

☐ I agree to call my health care provider for my test results in 10 to 14 days after each clinic visit. I may be asked to call again at a later date if all the test results are not ready.

☐ I will let the clinic staff know if I change my address, phone number, or my contact information.

☐ I will keep scheduled appointments so I can continue to receive good health care.

☐ If I fail to call the clinic within 10 to 14 days of my visit or fail to respond to the above written plan, and if a serious health problem is found, I understand the(agency name) _____staff may contact me by telephone, letter, or certified letter.

☐ I understand and agree with the above statements. I have had a chance to ask questions and have had my questions answered.

Date: Client Signature:

****

Please complete the following if interpretation of informed consent was required:

An interpreter was offered to the client. □ yes □ no
This form has been read to the client in the client's spoken language. □ yes □ no
Patient's Language (specify): _____
Interpreter's Name: (print or type name of interpreter) _____
Interpreter Services provided by (agency): _____

Date: Interpreter Signature:

****

Staff Use Only:

By my signature I affirm that:

☐ The client has read this form or had it read to her/him by an interpreter.

☐ The client states that s/he understands this information.

☐ The client has indicated that s/he has no further questions.

Date: Staff Signature:

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